

MANDATORY PHYSICIAN FORM

THIS FORM MUST BE RETURNED WITH BEFORE JUNE 15TH, 2006.

INDIVIDUALIZED ORDERS for

Camper: _____

DOB: _____ Camp: _____

The following form must be completed and signed by the child's physician and attached to the registration form. This form must be filled out and signed for all campers.

Campers taking any prescription medications while at camp must be able to self-administer the medication under the supervision of the Camp Health Director. Camp Health Directors are only permitted to dispense medications that are listed on this form by the child's doctor.

Physician's Name: _____ Phone #: _____

Address: _____ License #: _____

Signature (not stamped): _____ Date: _____

Standard Over the Counter/PRN Medications (The following medications are available and will be administered at the discretion of the Health Director, if approval is indicated by the camper's Healthcare Provider.):

Drug Name	Route	Dosage and Schedule	Indications	Physician's Order	Comments
Antibiotic Ointment	Topical	Per label instructions	Superficial Cuts/abrasions	Yes No	
Hydrocortisone Cream	Topical	Per label Instructions	Allergic reactions, (contact dermatitis, insect bites)	Yes No	
Calamine Lotion (or generic)	Topical	Per label Instructions	Allergic reactions, (hives, insect bite)	Yes No	
Hydrogen Peroxide	Topical	Per label Instructions	Superficial Cuts/Abrasions	Yes No	
Saline Solution/ Eye Wash		Per label Instructions	Dust/Sand In eyes	Yes No	
Sting Stop	Topical	Per label Instructions	Insect bite	Yes No	
Wound Wipes/ Alcohol Wipes/ Iodine Wipes	Topical	Per label instructions	Superficial Cuts/Abrasions	Yes No	

Prescription Medications (Please complete with the patient's current regimen for both scheduled and PRN medications.): ***This includes Epi-Pen's, Ritalin, etc.***

Drug Name	Route	Dosage and Schedule	Indications	Camper Health Care Provider Order	Comments

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Mandated Physician Form

UPDATED IMMUNIZATION RECORD

Immunization & Disease History

Please give all dates of immunization for: (Or attach photocopy of official record)***

Vaccine	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____				
Or Measles		_____	_____		Or Mumps	_____	_____
Or Rubella		_____	_____				
Haemophilus influenza B***		_____	_____	_____	_____	_____	_____
*** (Not required for schools. <u>Mandatory</u> for Camp)							
Hepatitis B		_____	_____	_____			
Varicella (Chicken Pox-not needed if they had the disease)					_____	_____	

Which of the following diseases has your child had?

- _____ Measles
- _____ Chicken pox
- _____ German measles
- _____ Mumps
- _____ Hepatitis
- _____ Tuberculosis
- _____ Rheumatic fever

Restrictions

Explain any physical, emotional or mental restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary):

DOCTOR'S SIGNATURE (NOT STAMPED AND LICENSE #) REQUIRED ON THE OTHER SIDE